RULEMAKING NOTICE FORM

Notice Number	**2015-204**	Rule Number	**He-W 530.01, 530.02, 530.04, and 530.07 (various); He-W 570.01 (various) and 570.13**

1. Agency Name & Address:

NH Dept. of Health & Human Services
Office of Medicaid Business and Policy
129 Pleasant Street
Concord, NH 03301

2. RSA Authority: **RSA 126-A:5, XXIV(f); RSA 126-A:5, XIX(f); RSA 161:4-a, X**

3. Federal Authority: **42 U.S.C. 1396-o and 1396o-1**

4. Type of Action:

Adoption	
Amendment	**X**
Repeal	
Readoption	
Readoption w/amendment	**X**

5. Short Title: **Medicaid Program Co-Payments**

6. (a) Summary of what the rule says and of any proposed amendments:

Chapter 3, Laws of 2014 (SB 413), which adopted RSA 126-a:5, XXIV-XXVI, requires that adults eligible for medical assistance under 42 U.S.C. §1396(a)(10)(A)(i)(VIII) enroll in a cost-effective Qualified Health Plan (QHP) certified for sale on the N.H. federally facilitated Marketplace and further required the Department to submit a §1115(a) Research and Demonstration waiver application to the Centers of Medicare and Medicaid Services (CMS) to implement the Premium Assistance Program (PAP). The Department received approval of its §1115(a) Research and Demonstration waiver, #11-W-00298/1, from CMS on March 4, 2015. The PAP waiver requires that those in the program with incomes above 100% of the federal poverty level (FPL) pay co-payments for some services and prescriptions.

Section 1902(a)(17) of the Social Security Act requires comparability among similarly situated Medicaid recipients. Because co-payments are required for PAP recipients with incomes above 100% FPL, the Department must also require the same co-payments for other Medicaid recipients at this income level. Currently, this population has co-payment requirements only for prescription drugs. The proposed rules add to the number of co-payments this population will be required to pay, which will be aligned with the co-payments for those recipients in the PAP. This proposal does not, however, change which groups of Medicaid recipients have co-payment obligations.

Sections of two separate rules are affected: He-W 530 Service Limits, Co-Payments, and Non-Covered Services, and He-W 570 Pharmaceutical Services. The proposal makes the following changes:

- **Definitions have been added for "non-preferred prescription drug" and "preferred prescription drug" to align with federal requirements at 42 CFR 447.53.**
- **Changes have been made to clarify that recipients with incomes equal to 100% FPL are exempt from co-payment obligations, in addition to those with incomes below 100% FPL. The Department has been in compliance with this provision of federal law (42 CFR 447.52) and is clarifying the rule to align with federal law.**
- **The proposed rules clarify that the following recipient categories are exempt from co-payment obligations, pursuant to federal law at 42 CFR 447.56(a), which became effective on January 1, 2014 (78 FR 42307):**

- **Women eligible through the Breast and Cervical Cancer Treatment Program (BCCP), pursuant to 42 CFR 435.213;**
- **Medicaid recipients receiving hospice care; and**
- **Individuals who are members of a federally recognized Indian tribe or Alaskan natives who have ever been served through the Indian Health Services Programs pursuant to 42 CFR 447.56(a)(x).**

- **In order to comply with the Social Security Act's comparability requirement, the following co-payments are being added to the rules:**
  - **$8.00 for each non-preferred drug prescription and refill dispensed;**
  - **$4.00 for each preferred drug prescription and refill dispensed;**
  - **$3.00 for each primary care provider visit to treat illness or injury;**
  - **$125 for each inpatient mental health admission or hospital admission, excluding maternity admissions;**
  - **$35 for high-cost imaging such as CT/PET scans, and MRIs;**
  - **$3.00 for each mental health outpatient visit;**
  - **$3.00 for each substance use disorder outpatient visit;**
  - **$3.00 for each physical therapy visit;**
  - **$3.00 for each occupational therapy visit;**
  - **$8.00 for each speech therapy visit;**
  - **$8.00 for each specialty physician visit;**
  - **$3.00 for each visit to other medical professionals such as an advanced practice registered nurse or a physician's assistant.**
  - **$125 for each inpatient substance use disorder treatment admission (for recipients eligible for Medicaid through the NHHPP); and**
  - **$3.00 for each chiropractor visit (for recipients eligible for Medicaid through the NHHPP);**

  In addition, the proposed rules also change the co-payment amounts for preferred prescription drugs from $1 to $4 and for non-preferred prescription drugs from $4 to $8. The proposal also aligns with federal requirements that if the provider determines a preferred drug would be less effective for the recipient, have an adverse effect, or both, the co-payment for the non-preferred drug will be $4 (42 CFR 447.53(e)). The rule also clarifies that if a prescription drug is not identified as either preferred or non-preferred the co-payment will be $4.

- **In order to comply with federal law found at 42 CFR 447.56(f), He-W 530.04(c) states that recipients' co-payment obligations will be suspended for the remainder of the calendar year quarter when the total co-payments made out of pocket by the recipient reaches 5% of the recipient's household income during the quarter.**
- **"Prior authorization agent" is being removed from He-W 530.07 because the Department itself will now be conducting the prior authorization reviews described in that section.**

6. (b) Brief description of the groups affected:

These rules affect approximately 5,500 standard Medicaid recipients with incomes above 100% federal poverty level and who are not otherwise exempt from co-payments. These rules also affect NH enrolled Medicaid providers of services which are now subject to co-payments listed above.

6. (c) Specific section or sections of state statute or federal statute or regulation which the rule is intended to implement:

Rule	Federal Reg./RSA
He-W 530.01	RSA 318:1; 21 CFR 310.6; 42 CFR 440.120; 21 USC 802(6), 42 CFR 447.53
He-W 530.02	42 USC 1396o; 42 CFR 447.53, 42 CFR 447.56
He-W 530.04	42 USC 1396o; 42 CFR 447.53, 42 CFR 438.114(a), 42 CFR 447.26(b), 42 CFR 447.56
He-W 530.07(e), (f) intro & (2), (h), (i), (m) and (n)	42 CFR 440.230(d); 42 CFR 431.107; RSA 126-A:5, VII
He-W 570.01(s), (z), (aa)	RSA 318:1, VII; RSA 318:1, XV, RSA 318:1, XVI, RSA 318:21; RSA 126-A:3, III(b), 21CFR 310.6, 42 CFR 440.120, 42 CFR 447.53
He-W 570.13	42 USC 1396o; 42 CFR 447.53, 42 CFR 447.56

7. Contact person for copies and questions including requests to accommodate persons with disabilities:

Name: **Michael Holt** Title: **Rules Coordinator**

Address: **Dept. of Health and Human Services**
Administrative Rules Unit
129 Pleasant St.
Concord, NH 03301

Phone #: **271-9234**

Fax#: **271-5590**

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TTY/TDD Access: Relay NH 1-800-735-2964 or dial 711 (in NH)

The proposed rules may be viewed and downloaded at:
http://www.dhhs.nh.gov/oos/aru/comment.htm

8. Deadline for submission of materials in writing or, if practicable for the agency, in the electronic format specified: **Friday, January 29, 2016**

☒Fax ☒E-mail ☐Other format (specify):

9. Public hearing scheduled for:

Date and Time: **Friday, January 22, 2016 at 1:30 PM**

Place: **DHHS Brown Bldg., Auditorium, 129 Pleasant St., Concord, NH**

10. Fiscal Impact Statement (Prepared by Legislative Budget Assistant)

FIS # **15:220**, dated **12/21/15**

1. **Comparison of the costs of the proposed rule(s) to the existing rule(s):**
   When compared to the existing rules, the proposed rules may increase costs to state citizens to the extent that they are Medicaid recipients subject to copayments imposed by the rule, and will have an indeterminable fiscal impact on state funds and independently-owned businesses. There will be no impact on political subdivisions.
2. **Cite the Federal mandate. Identify the impact of state funds:**
   New Hampshire state law (Chapter 3, Laws of 2014) requires that adults eligible for medical assistance under 42 USC 1396(a)(10)(A)(i)(VIII) enroll in a cost-effective Qualified Health Plan (QHP) certified for sale on the NH federally facilitated marketplace and further required the Department to submit a 1115(a) research and demonstration waiver application to the Centers for Medicare and Medicaid Services (CMS) to implement the Premium Assistance Program (PAP). The

PAP waiver requires that those in the program with incomes above 100 percent of the federal poverty level (FPL) pay copayments for some services and prescriptions.

Section 1902(a)(17) of the Social Security Act requires comparability among similarly situated Medicaid recipients. Because copayments are required for PAP recipients with incomes above 100 percent of the FPL, the Department must also require the same copayments for other Medicaid recipients at this income level. Currently, this population has copayment requirements for prescription drugs only. The proposed rules add to the number of copayments this population will be required to pay, which will be aligned for the copayments for those recipients in the PAP. The proposed rule does not, however, change the groups of Medicaid recipients that have copayment obligations.

3. Cost and benefits of the proposed rule(s):

With the exception of the copayments described in (B) below, any costs or benefits associated with the proposed rule can be generally attributed to the comparability requirements in the Social Security Act section 1902(a)(17), described in (2) above.

A. To State general or State special funds:

For those Medicaid recipients in Medicaid Managed Care (MCM), the new copayment requirements identified in (B) below will not result in a benefit to the state because the collection of the copayment from the recipient occurs at the provider level and any reduction in fee paid to the provider would occur between the Managed Care Organization (MCO) and the provider.

For those Medicaid recipients in Fee for Service (FFS), the new copayment requirements may result in a benefit to the Department. However, the Department is not able to estimate that benefit because it does not know how many people in FFS have a copayment obligation. The collection of the copayment from the recipient occurs at the provider level, and any reduction in fee paid to the provider will occur between the Department and the provider. The Department expects that Medicaid recipients with cost-sharing obligations will pay them to the providers. Any benefit obtained by the Department for reducing the amount paid to the provider may be offset by the administrative costs associated with preparing the New Heights and MMIS systems to identify recipients with cost sharing obligations and with tracking cost-sharing obligations per quarter.

B. To State citizens and political subdivisions:

The proposed rule will increase costs for state citizens to the extent they are Medicaid recipients subject to the copayments imposed by the rule. Although the copayments are mandated by the federal comparability requirement outline in (2) above, the copayment amounts themselves are attributable to the proposed rules. The proposed amounts were determined by an actuary to meet federal regulations which require a 94.6% actuarial value in order to be approved for sale on the federal marketplace in New Hampshire. The Department expects that approximately 5,500 Medicaid recipients will be affected by the proposed copayments, which are as follows:

- $8 for each specialty drug prescription and refill dispensed;
- $4 for each preferred drug prescription and refill dispensed;
- $3 for each primary care provider visit to treat illness or injury;
- $125 for each inpatient mental health admission, inpatient substance use disorder treatment admission or hospital admission, excluding maternity admissions;
- $35 for high-cost imaging such as CT/PET scans and MRIs;
- $3 for each mental health outpatient visit;
- $3 for each substance use disorder outpatient visit;
- $3 for each physical therapy visit;
- $3 for each occupational therapy visit;
- $8 for each speech therapy visit;
- $3 for each chiropractor visit (for recipients eligible through the NHHPP);

- $8 for each specialty physician visit;
- $3 for each visit to other medical professionals such as an advanced practice registered nurse or a physician's assistant; and
- $125 for each inpatient substance use disorder treatment admission (for recipients eligible through the NHHPP).

The proposed rules also change the copayment amounts for preferred prescription drugs from $1 to $4 and for non-preferred prescription drugs from $4 to $8. The proposal also aligns with federal requirements that if the provider determines a preferred drug would be less effective for the recipient, have an adverse effect, or both, the copayment for the non-preferred drug will be $4 (42 CFR 447.53(e)). The rule also clarifies that if a prescription drug is not identified as either preferred or non-preferred the copayment will be $4.

In addition, in order to comply with the federal requirement found at 42 CFR 447.56(f), the proposed rule states that recipients' copayment obligations will be suspended for the remainder of the calendar year quarter when the total copayments made out of pocket by the recipient reaches 5 percent of the recipient's household income during the quarter.

Finally, the proposed rules clarify that the following recipient categories are exempt from federal regulations, pursuant to 42 CFR 447.56(a), which became effective on January 1, 2014 (78 FR 42307):

- Women eligible through the Breast and Cervical Cancer Treatment Program (BCCP), pursuant to 42 CFR 435.213;
- Medicaid recipients receiving hospice care; and
- Individuals who are members of a federally-recognized Indian tribe or Alaskan natives who have ever been served through the Indian Health Services Programs pursuant to 42 CFR 447.56(a)(x).

The Department notes that the proposed rules align with current practice, which is to exempt the above groups from copays consistent with federal law. Individuals in the above categories have seen decreased costs as a result of exemption from copays.

C. To Independently owned businesses:

Under FFS, the collection of the copayment from the recipient occurs at the provider level, and any reduction in fee paid to the provider will occur between the Department and the provider. The Department expects that Medicaid recipients with cost-sharing obligations will pay them to the providers. This rule will impact businesses in that they may have an administrative cost associated with the collection of copayments from Medicaid recipients. The Department is unable to estimate the extent of any cost increases.

Because the rule requires Medicaid providers to provide services regardless of recipient payment of the copayments, the Department acknowledges that recipient compliance or lack thereof may impact payment to Medicaid-enrolled providers. However, Medicaid recipients with copayment obligations are expected to pay them on the date of service. Due to the nature of the relationship between Medicaid providers and the MCOs regarding reimbursement for services, the MCOs may be impacted as well. The Department is unable to accurately predict the extent of this impact.

11. Statement Relative to Part I, Article 28-a of the N.H. Constitution:

The proposed rules modify an existing program or responsibility, but do not mandate any fees, duties or expenditures on the political subdivisions of the state, and therefore do not violate Part I, Article 28-a of the N.H. Constitution.

CHAPTER HE-W 500 MEDICAL ASSISTANCE

PART He-W 530 SERVICE LIMITS, CO-PAYMENTS, AND NON-COVERED SERVICES

Readopt with amendment He-W 530.01, effective 3-12-08 (Document #9103), as amended effective 7-1-12 (Document #10139), to read as follows:

He-W 530.01 Definitions.

(a) "Co-payment" means an amount to be paid by the recipient to an enrolled New Hampshire ~~Title XIX program~~ medicaid provider.

(b) "Department" means the New Hampshire department of health and human services.

(c) "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or the recommendations of physician specialists practicing in relevant clinical areas or of various physician specialty societies.

(d) "Medicaid" means the Title XIX and Title XXI programs administered by the department, which makes medical assistance available to eligible individuals.

(e) "Medically necessary" means health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

(1) Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;

(2) Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;

(3) No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and

(4) Not experimental, investigative, cosmetic, or duplicative in nature.

(f) "Multi-source pharmaceutical product" means a product which is available from more than one manufacturer.

(g) "Non-preferred prescription drug" means a medication that has been determined to have an alternative drug available that is clinically equivalent.

(h) "Preferred prescription drug" means a medication that has been clinically reviewed and approved by the NH Pharmacy and Therapeutics Committee or the NH Drug Use Review Board and has been included in the department's Preferred Drug List based on its proven clinical and cost effectiveness.

(i) "Preferred Drug List (PDL)" means a formal published list of specific prescription drug products by brand and generic name divided into 2 separate categories as either preferred or non-preferred.

~~(g) "Prior authorization agent" means an individual or organization contracted by the department, responsible for reviewing all service limit override requests.~~

(~~h~~j) "Provider" means an entity or individual who furnishes health care services or supplies to medicaid recipients under an agreement with the department, and is licensed or certified pursuant to applicable state law to provide such services and supplies.

(~~i~~k) "Recipient" means any individual who is eligible for and receiving medical assistance under the medicaid program.

(~~j~~l) "Service" means medical care or a medical product for which payment is made by ~~a~~ New Hampshire ~~Title XIX program~~medicaid.

(~~k~~m) "Service limit" means a finite number of visits or units of service per recipient per specified time period for which payment is made by ~~a~~ New Hampshire ~~Title XIX program~~medicaid.

(~~l~~n) "Single source pharmaceutical product" means a brand name product which is available from only one manufacturer.

(~~m~~o) "State fiscal year" means July 1 through June 30.

(~~n~~p) "Third party entity" means the agency under contract with the department to collect and process premium payments for ~~Title XIX~~ medicaid recipients.

(~~o~~q) "Title XIX" means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

(~~p~~r) "Title XXI" means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

(~~q~~s) "Unit" means a determinate quantity for which a particular service is rendered.

(~~r~~t) "Visit" means all services provided to a recipient per appointment or encounter with a provider.

Readopt with amendment He-W 530.02, effective 8-26-15 (Document #10915), to read as follows:

He-W 530.02 Recipients Subject to Service Limits, Co-Payments, and Non-Covered Services.

(a) All recipients shall be subject to service limits in accordance with He-W 530.03.

(b) All recipients shall be subject to the co-payments specified in He-W 530.04, except for:

(1) Recipients with income at or below 100% of the federal poverty level (FPL);

(2) Recipients residing in a nursing facility, hospital, intermediate care facility for individuals with intellectual disabilities, or other medical institution;

(3) Recipients participating in the home and community based care (HCBC) waiver programs;

(4) Recipients receiving services that relate to pregnancy, in accordance with 42 CFR 447.53(b)(2), or any other medical condition that might complicate the pregnancy; ~~and~~

(5) Recipients under the age of 18;~~.~~

(6) Women eligible through the Breast and Cervical Cancer Treatment Program, pursuant to 42 CFR 435.213;

(7) Recipients receiving hospice care pursuant to He-W 544: and

(8) Individuals who are members of a federally recognized Indian tribe or Alaskan natives who have ever been served through the Indian Health Services Programs, pursuant to 42 CFR 447.56(a)(x).

(c) All recipients shall be subject to non-covered services provisions in accordance with He-W 530.05.

Readopt with amendment He-W 530.04, effective 11/18/14 (Document #10716,) to read as follows:

He-W 530.04 Co-Payments.

(a) Recipients subject to co-payments shall make co-payments to the pharmacy provider for pharmaceutical products as follows, except as noted in (3~~b~~) below:

(1) For recipients eligible for medicaid through the New Hampshire Health Protection Program (NHHPP):

a. A co-payment in the amount of $4.00 shall be required for each ~~brand name~~preferred prescription drug~~, each compound product prescription,~~ and each refill of a preferred ~~brand name or compound product~~ prescription drug dispensed; and

b. A co-payment in the amount of $8~~1~~.00 shall be required for each ~~generic~~ non-preferred prescription drug and each refill of a non-preferred prescription drug dispensed~~; and~~ unless the prescribing provider determines that a preferred prescription drug will be less effective for the recipient, will have adverse effects for the recipient, or both, in which case the co-payment for the non-preferred prescription drug shall be $4.00; and

c. A co-payment in the amount of $4.00 shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug;

(2) For all other recipients subject to co-payments as required by this part:

a. A co-payment in the amount of $4~~1~~.00 shall be required for each ~~generic~~ preferred prescription drug and each refill of a preferred prescription drug dispensed;~~ and~~

b. A co-payment in the amount of $8~~2~~.00 shall be required for each ~~brand name~~non-preferred prescription drug~~, each compound product prescription,~~ and each refill of a ~~brand name or compound product~~non-preferred prescription drug dispensed~~.~~ unless the prescribing provider determines that a preferred drug will be less effective for the recipient, will have adverse effects for the recipient, or both, in which case, the co-payment shall be $4.00; and

c. A co-payment in the amount of $4.00 shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug; and

(3~~b~~) Co-payments for pharmaceutical products shall not be required:

a.~~(1)~~ Of recipients exempt from co-payments in accordance with He-W 530.02(b);

b.~~(2)~~ For family planning products; and

c.~~(3)~~ For Clozaril (Clozapine) prescriptions.

(b) Recipients subject to co-payments shall make co-payments to the provider for services as follows, except as noted in (3) below:

(1) For recipients eligible for medicaid through the NHHPP, co-payments as described in (2) below and the following co-payments:

a. A co-payment in the amount of $125 for each inpatient substance use disorder treatment admission; and

b. A co-payment in the amount of $3.00 for each chiropractor visit;

(2) All other recipients shall make co-payments to providers as follows:

a. A co-payment in the amount of $125 for each inpatient mental health admission, or hospital admission, excluding maternity admissions;

b. A co-payment in the amount of $125 for each inpatient hospital admission, excluding maternity admissions;

c. A co-payment in the amount of $35 for high-cost imaging such as CT/PET scans and MRIs;

d. A co-payment in the amount of $3.00 for each visit as follows:

1. Primary care provider visit;

2. Behavioral health outpatient visit;

3. Physical therapy visit;

4. Occupational therapy visit; and

5. Other medical professional visit to other medical professional such as an advanced practice registered nurse or a physician's assistant; and

e. A co-payment in the amount of $8.00 for each visit as follows:

1. Physician specialist visit; and

2. Speech therapy visit; and

(3) Recipients shall not be responsible for a co-payment for the following services:

a. Emergency services needed to evaluate or stabilize an emergency medical condition as defined in 42 CFR 438.114(a);

b. Provider-preventable services as described in 42 CFR §447.26(b);

c. Services furnished to pregnant women, including counseling and pharmacotherapy for cessation of tobacco use;

d. Family planning services and supplies; and

e. Preventive services.

(c) Pursuant to 42 CFR 447.56(f), co-payment obligations shall be suspended for the remainder of the calendar year quarter when the total co-payments made out of pocket by the recipient reaches 5 percent of the recipient's household income.

(d) All recipients subject to co-payments required by this part shall not be denied services by any medicaid enrolled provider on account of the recipient's inability to pay the co-payments required by this part.

Amend He-W 530.07(e), (f)(2), (h), (i), (m) and (n) effective 5-23-14 (Document #10605), so that (e), (f) intro, (f)(2), (h), (i), (m), and (n) are cited and read as follows:

He-W 530.07 Prior Authorization of Services Which Exceed Service Limits.

(e) Providers shall direct requests for prior authorization of services in excess of the limits described in He-W 530.03 to the department~~'s prior authorization agent~~.

(f) Prior to payment by the department, requests for prior authorization of covered services in excess of the limits described in He-W 530.03 shall:

(2) Be submitted in writing to the department~~'s prior authorization agent~~ via mail, e-mail or fax;

(h) Except as allowed by He-W 573.10, prior authorization requested in accordance with (b) through (g) above shall be approved by the department~~'s prior authorization agent~~ if the department~~'s prior authorization agent~~ determines that the requested additional services meet the definition of medically necessary or that coverage is supported by clinical documentation provided in accordance with (g)(8) above.

(i) If the department~~'s prior authorization agent~~ approves the prior authorization request in accordance with (h) above, the state's fiscal agent shall send written confirmation of the approval to the provider.

(m) Except as allowed by He-W 573.10, the department shall deny a prior authorization request when the department~~'s prior authorization agent~~ determines that the requested additional services do not meet the definition of medically necessary and that the coverage is not supported by clinical documentation provided in accordance with (g)(8) or (9) above.

(n) If the department~~'s prior authorization agent~~ denies the prior authorization request, the department~~'s prior authorization agent~~ shall forward a notice of denial to the recipient and the wheelchair van provider.

Amend He-W 570.01, effective 12-21-10 (Document #9831), as amended effective 7-1-12 (Document #10139), by inserting new paragraphs (s), (z), and (aa) and renumbering subsequent paragraphs, so that (s), (z), and (aa) are cited and to read as follows:

PART He-W 570 PHARMACEUTICAL SERVICES

He-W 570.01 Definitions.

(s) "Non-preferred prescription drug" means a medication that has been determined to have an alternative drug available that is clinically equivalent.

(z) "Preferred prescription drug" means a medication that has been clinically reviewed and approved by the NH Pharmacy and Therapeutics Committee or the NH Drug Use Review Board and has been included in the department's Preferred Drug List based on its proven clinical and cost effectiveness.

(aa) "Preferred Drug List (PDL)" means a formal published list of specific prescription drug products by brand and generic name divided into 2 separate categories as either preferred or non-preferred.

Readopt with amendment He-W 570.13, effective 11-18-14 (Document #10716), to read as follows:

He-W 570.13 Prescription Co-payment.

(a) Recipients shall make co-payments to the pharmaceutical provider for pharmaceutical products as follows, except as set forth in (b) below:

(1) For recipients eligible for medicaid through the New Hampshire Health Protection Program (NHHPP):

a. A co-payment in the amount of $4.00 shall be required for ~~each brand name~~preferred prescription drug~~, each compound product prescription,~~ and each refill of a ~~brand name or compound product~~ preferred prescription drug dispensed;~~ and~~

b. A co-payment in the amount of $8~~1~~.00 shall be required for each ~~generic~~ non-preferred prescription drug and each refill of a non-preferred prescription drug dispensed~~; and~~unless the prescribing provider determines that a preferred prescription

drug will be less effective for the recipient, will have adverse effects for the recipient, or both, in which case the co-payment shall be $4.00; and

c. A co-payment in the amount of $4.00 shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug.

(2) For all other recipients:

a. A co-payment in the amount of $41.00 shall be required for each preferred ~~generic~~ prescription drug and each refill of a preferred prescription drug dispensed; ~~and~~

b. A co-payment in the amount of $82.00 shall be required for each non-preferred ~~brand name prescription, each compound product~~ prescription drug~~,~~ and each refill of a ~~brand name or compound product prescription~~ non-preferred prescription drug dispensed unless~~.~~ the prescribing provider determines that a preferred prescription drug will be less effective for the recipient, will have adverse effects for the recipient, or both, in which case the co-payment shall be $4.00; and

c. A co-payment in the amount of $4.00 shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug.

(b) Co-payments for pharmaceutical products shall not be required:

(1) Of recipients with income at or below 100% of the federal poverty level (FPL);

(2) Of recipients in a nursing facility, hospital, intermediate care facility for individuals with intellectual disabilities, or other medical institution;

(3) Of recipients participating in the home and community based care (HCBC) waiver programs;

(4) Of recipients receiving services that relate to pregnancy in accordance with 42 CFR 447.53 (b)(2), or any other medical condition that might complicate the pregnancy;

(5) Of recipients under the age of 18;

(6) For family planning products; ~~and~~

(7) For Clozaril (Clozapine) prescriptions;

(8) Of women eligible through the Breast and Cervical Cancer Treatment Program, pursuant to 42 CFR 435.213;

(9) Of recipients receiving hospice care pursuant to He-W 544; and

(10) Of individuals who are members of a federally recognized Indian tribe or Alaskan natives who have ever been served through the Indian Health Services Program, pursuant to 42 CFR 447.56(a)(x).

APPENDIX B

RULE	STATE OR FEDERAL STATUTE THE RULE IMPLEMENTS
He-W 530.01	RSA 318:1; 21 CFR 310.6; 42 CFR 440.120; 21 USC 802(6), 42 CFR 447.53
He-W 530.02	42 USC 1396o; 42 CFR 447.53, 42 CFR 447.56
He-W 530.04	42 USC 1396o; 42 CFR 447.53, 42 CFR 438.114(a), 42 CFR 447.26(b), 42 CFR 447.56
He-W 530.07(e), (f) intro & (2), (h), (i), (m) and (n)	42 CFR 440.230(d); 42 CFR 431.107; RSA 126-A:5, VII
He-W 570.01(s), (z), (aa)	RSA 318:1, VII; RSA 318:1, XV, RSA 318:1, XVI, RSA 318:21; RSA 126-A:3, III(b), 21CFR 310.6, 42 CFR 440.120, 42 CFR 447.53
He-W 570.13	42 USC 1396o; 42 CFR 447.53, 42 CFR 447.56